The University Of
TAMPA
DICKEY HEALTH AND WELLNESS CENTER

Authorization for Release of Patient Health Information

PATIENT NAME: First and Last	Student ID#:	DOB: Month/Day/Year	AGE:
TELEPHONE#:	Emergency Contact Name:	Emergency Contact Ph#:	

SECTION A:

The undersigned hereby authorizes and requests the Dickey Health and Wellness Center to:

Release my medical records to ‰ Health Care Facility or ‰ Previous PCP or ‰ Parent(s) ‰ Rapid Trace ‰ Release my current medical status to the athletic department at The University of Tampa or ‰ The University of Tampa/my professors or ‰ Self.

Complete SECTION C for specific information requested.

Enter contact info below for the Health Care Facility or Previous PCP or Parent(s) indicated above.

Full Name(s):____________________ Address:________________________________ City_______ State__________ Zip:_____

Telephone :_________________ Fax number___________________

OR

SECTION B:

The undersigned hereby authorizes and requests Name of Health Care Facility or PCP_____________ Phone :____________________ Fax:_________

to release medical, alcohol, AND/OR substance abuse information contained in patient's medical records for the purpose of continued care to: Dickey Health and Wellness Center, The University of Tampa

401 W. Kennedy Blvd., Tampa FL 33606 Phone:

(813) 253-6250 – Fax: (813) 258-7413

SECTION C:

Specific information requested to release (check all that apply):

‰ PAP/Contraception Records	‰ X-ray and Imaging Reports	‰ Immunization Record
‰ Consultation Reports	‰ ER Record	‰ Most Recent History and Physical
‰ Laboratory Results	‰ Entire Record	‰ Progress Notes
‰ Verbal only (please specify)________________________		‰ Other________________________

I authorize the release of information covering the period(s) of healthcare from: Date(s) to: Date(s)__________

I understand that signing this authorization is voluntary. My treatment, enrollment in a health plan, or eligibility for benefits will not be conditioned authorization of this disclosure. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authoriza so in writing and present my written revocation to the Dickey Health and Wellness Center. I understand that information contained in my medical re contain HIV/AIDS testing, results, and/or treatment records.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentially rules. If I have questions a disclosure of health information, I can contact the Director of Medical Services at (813) 253-6250. The Dickey Health and Wellness Center will respo request within 48 to 72 hours from date of receipt.

This authorization will expire: Date_________. If not otherwise specified, this release will expire within 12 months from the date signed.

In what format would you like to receive your records? (choose one):

‰ Paper (please send to the mail address in section A) ‰ Email-message using secure email (F X U8 UQHLQYWPUTVDLPWS\DX GRHQOOV)

‰ I wish to pick up my records (during the Dickey Health and Wellness business hours)

Date:

Signature of Patient or Guardian | Relation to Patient | Month/Day/Year

Date:

Signature of Office Witness or Notary | Printed Name of Witness | Month/Day/Year